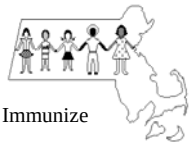
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
IMMUNIZATION PROGRAM

For Healthier Lives



Immunize

Provider Enrollment Form

2008

Please type or print *neatly*

Vaccine Provider Site Number: ___ ___ ___ ___ ___

Name of Facility or Practice: _____

Mailing Address: _____

_____

_____

City State Zip

Shipping Address: (P.O. Boxes are not acceptable shipping addresses)

_____

_____

City State Zip

Telephone: _____

Fax: _____

Contact (name): _____

E-mail address: _____

If possible, please list a general e-mail address for your facility. Personal e-mail addresses are acceptable if your facility does not have a general e-mail.

Hours of Operation

Monday: Thursday:

Tuesday: Friday:

Wednesday:

Mailing Contact:

Medical Director's Name: _____

Medical Director License No: _____

Medicaid Provider Number*: _____

Practice Type (please check only one)

- ☐ Assited Living/Adult Day Care (26)
- ☐ Board of Health/Health Dept (01)
- ☐ College (Private) (20)
- ☐ College (Public) (05)
- ☐ Community Health Center (03)
- ☐ Correctional Facility (06)
- ☐ Council On Aging (10)
- ☐ Employee Health (24)
- ☐ Family Practice (14)
- ☐ Home Health Agency/Hospice (25)
- ☐ Hospital (Private) (12)
- ☐ Hospital (Public) (02)
- ☐ Internal Medicine (17)
- ☐ LTCF/Nursing Home/Rest Home (22)
- ☐ Multi-Specialty Center (27)
- ☐ Other (Specify) (09 pub/23 priv)

  ↓ _____
- ☐ OB/GYN (18)
- ☐ Pediatric Practice (15)
- ☐ School (Private) (19)
- ☐ School (Public) (04)
- ☐ Specialty Practice (16)
- ☐ State Agency (07)
- ☐ VNA (08)
- ☐ Walk-In (21)

Agreement to Comply with Federal and State Requirements for Vaccine Administration

The Vaccines for Children (VFC) Program is a component of the Massachusetts Department of Public Health (MDPH) Immunization Program. To receive vaccine provided by the MDPH Immunization Program and VFC program, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, HMO, health department, hospital, clinic, or other entity of which I am the medical director or equivalent, agree to:

1. Read and comply with the federal and state requirements for vaccine ordering, accountability, management and administration as outlined in the enclosed *Guidelines for Compliance with Federal Vaccine Administration Requirement,* including the section on fraud and abuse.
2. Use the Vaccines for Children (VFC) Program eligibility screening form provided to me by the MDPH Immunization Program to determine how many children in my practice are eligible for VFC vaccine. Children less than 19 years of age in the following categories are eligible for VFC vaccine: (a) enrolled in Medicaid, or (b) without health insurance, or (c) American Indian (Native American) or Alaska Native or (d) underinsured children seen at federally qualified health centers (FQHC) and rural health centers (RHC).
3. Maintain all records related to the VFC Program for at least a period of 3 years. These records include the authorized representative's response about a child's eligibility, temperature logs, and receipt of all state provided vaccines. Release of such records will be bound by the privacy protection of Federal Medicaid law.
4. If requested, make such records available to the MDPH Immunization Program or the federal Department of Health and Human Services (DHHS).
5. Administer state-supplied vaccine only to those children and adults determined eligible as defined in the most recent version of the *Childhood Vaccine Availability Table*, the *Adult Vaccine Availability Table* and the *Summary of the Advisory Committee on Immunization Practices Recommended Groups for Vaccination.*
6. Comply with the appropriate immunization schedule, dosage, and contraindications that are established by the Department of Health and Human Services' Advisory Committee on Immunization Practices (ACIP), unless (a) in making a medical judgement in accordance with accepted medical practice, I deem such compliance to be medically inappropriate or (b) the particular requirement is not in compliance with Massachusetts law, including laws relating to religious or other exemptions.[1]
7. Provide the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act. This includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting Systems (VAERS).
8. Not impose a charge for the cost of state-supplied vaccine. VFC vaccine will not be given to non-VFC eligible children.
9. Not impose a charge for the administration of the vaccine to the non-Medicaid VFC-eligible child in any amount higher than the maximum fee of $15.78/dose established by DHHS. For Medicaid VFC-eligible children, accept the reimbursement for vaccine administration set by the Massachusetts Medicaid agency or the contracted Medicaid health plans. Administration fees may be billed to third party payers if they cover such costs.
10. Not deny state-supplied vaccine to an established patient due to the inability of the child's parent/guardian/individual of record to pay the administration fee. "Established patient" applies only to private providers. FQHCs must administer state-supplied vaccine to any VFC-eligible child who presents for immunization services at their facility.
11. Provide, with this agreement, a list of all physicians, physician assistants, nurse practitioners and nurse-midwives at this facility who prescribe vaccines, along with their medical license numbers and Medicaid numbers, where applicable.
12. I or the Commonwealth may terminate this agreement at any time for personal reasons or failure to comply with these requirements. If I choose to terminate the agreement, I agree to properly return any unused vaccine.

Medical Director statement: I certify that I have read and agree to the requirements listed above pertaining to participation in the MDPH Immunization Program.

Medical Director's signature: _____

Vaccine Provider Site Number: ____ ____ ____ ____ ____ Date: ____/____/___

This record is to be submitted to and kept on file at the Massachusetts Department of Public Health and must be updated annually.

[1] The ACIP immunization schedule is compatible with the AAP and AAFP recommendations.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
IMMUNIZATION PROGRAM
VACCINES FOR CHILDREN PROGRAM

Practice Profile Form

2008

Vaccine Provider Site Number ___ ___ ___ ___ ___

Name of Facility or Practice _____

This form must be completed annually by all public and private health care practices that receive vaccines from the MDPH Immunization Program for patients under 19 years old. Please project as accurately as possible how many patients you will **vaccinate** in 2008. **All patient projections must be based on data and not estimates. Use numbers, not percentages.** Your billing system may be helpful in providing this information. Data should reflect the entire facility or practice. **Do not count a child in more than one category.**

Patient Projections for 2008

Please fill in all boxes	**< 1 Yr Old**	**1–6 Yrs Old**	**7–18 Yrs Old**	**TOTAL**
1. Enrolled in Medicaid, or Mass Health or any MCO, **if enrolled through a Medicaid contract.**				
2. No Health Insurance Also use this category for patients enrolled in the Children's Medical Security Plan.				
2. American Indian (Native American) or Alaska Native				
4. Subtotal (add items 1,2 & 3)				
5. Children with Health Insurance (paid for by parents, employers, or both)				
6. TOTAL CHILDREN (item 4 + item 5)				

If Applicable:
7. TOTAL ADULTS (19 years and older) _____

Data source* used to determine patient projections (please check only one):

☐ **Billing/Claims Data** ☐ **Encounter/Screening Data**

☐ **Other (Please Describe):** _____

*See instructions for description of each method.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
IMMUNIZATION PROGRAM
VACCINE FOR CHILDREN PROGRAM

Provider List

Vaccine Provider Site Number ___ ___ ___ ___ ___ **Date** _____

List below all physicians, physician assistants, nurse practitioners and nurse-midwives who **prescribe** vaccines in your practice. Do **not** include other staff who may administer vaccines (i.e.: RNs). Please include the provider's medical license number and Medicaid provider number where applicable.*

Last Name, First, MI	**Title** (MD, DO, PA, NP, CNM)	**Medical License No.**	**Medicaid Provider No.***

*****For health centers, hospitals, and other large practices a single Medicaid number for the facility is sufficient; however, individual medical license numbers for each physician is still required.

Please copy additional sheets if necessary.